Short Summary of Key Provisions in H.R. 3962

The Government Takeover

Creation of Exchange: The bill creates within the federal government a nationwide Health Insurance Exchange. Uninsured individuals would be eligible to purchase an Exchange plan, as would those whose existing employer coverage is deemed "insufficient" by the federal government. Once deemed eligible to enroll in the Exchange, individuals would be permitted to remain in the Exchange until becoming Medicare-eligible—a provision that would likely result in a significant movement of individuals into the bureaucrat-run Exchange over time. Employers with 25 or fewer employees would be permitted to join the Exchange <u>in its first year</u>, with employers with 25-50 employees permitted to join in its second year. Employers with fewer than 100 employees would be permitted to enroll in the third year, and <u>all employers would also be eligible to join, if permitted to do so by the Commissioner</u>. Many may note the limits on employer eligibility in the first several years are significantly higher than in H.R. 3200, thus expanding the scope of the government-run Exchange.

Exchange Benefit Standards: The bill requires the Commissioner to establish benefit standards for all plans. These onerous, bureaucrat-imposed standards would hinder the introduction of innovative models to improve enrollees' health and wellness—and by insulating individuals from the cost of health services with restrictive cost-sharing, could raise health care costs.

Government-Run Health Plans: The bill requires the Department of Health and Human Services to establish a "public health insurance option" through the Exchange. The bill states the plan shall comply with requirements related to other Exchange plans. Empowered to collect individuals' personal health information, with access to federal courts for enforcement actions and $2 billion in "start-up funds"—as well as 90 days' worth of premiums as "reserves"—from the Treasury, the bill's headings regarding a "level playing field" belie the reality of the plain text. In addition, the bill requires the Secretary to establish premium rates that can fully finance the cost of benefits and administrative costs, but there would always be the implicit backing of the federal government.

The bill provides that the government-run plan shall enlist all Medicare providers unless physicians affirmatively decide to opt-out of the program. While the Secretary will be required to "negotiate" reimbursement rates with doctors and hospitals, **nothing in the bill prohibits the Secretary from using such negotiation to impose Medicare reimbursement levels on providers as part of a government-imposed "negotiation**." Should such a scenario occur, the Lewin Group has estimated that as many as 114 million individuals could lose access to their current coverage under a government-run plan—and that a government-run plan reimbursing at the rates contemplated by the legislation would actually result in a net $16,207 decrease in reimbursements per physician per year, even after accounting for the newly insured.

The bill requires the Secretary to "establish conditions of participation for health care providers" under the government-run plan—however it includes no guidance or conditions under which the Secretary must establish those conditions. Many may be concerned that the bill would allow the Secretary to prohibit doctors from participating in other health plans as a condition of participation in the government-run plan—a way to co-opt existing provider networks and subvert private health coverage.

"Low-Income" Subsidies: The bill provides subsidies only through the Exchange, again putting employer health plans at a disadvantage. Individuals with access to employer-sponsored insurance whose group premium costs exceed 12 percent of adjusted gross income would be eligible for subsidies.

The bill provides that the Commissioner may authorize State Medicaid agencies—as well as other "public entit[ies]"—to make determinations of eligibility for subsidies and exempts the subsidy regime from the five-year waiting period on federal benefits established as part of the 1996 welfare reform law (P.L. 104-193). The second provision would give individuals a strong incentive to emigrate to the United States in order to obtain subsidized health benefits without a waiting period. Despite the bill's purported prohibition on payments to immigrants not lawfully present, and the insertion of a citizenship verification provision, some may be concerned that the provisions as drafted would not require individuals to verify their identity when confirming eligibility for subsidies—encouraging identity fraud while still permitting undocumented immigrants and other ineligible individuals from obtaining taxpayer-subsidized benefits.

Premium subsidies provided would be determined on a six-tier sliding scale, such that individuals with incomes under 133 percent of the Federal Poverty Level (FPL, $29,327 for a family of four in 2009) would be expected to pay 1.5 percent of their income, while individuals with incomes at 400 percent FPL ($88,200 for a family of four) would be expected to pay 12 percent of their income. Subsidies would be based on adjusted gross income (AGI), meaning that individuals with total incomes well in excess of the AGI threshold could qualify for subsidies.

The bill further provides for cost-sharing subsidies, such that individuals with incomes under 133 percent FPL would be covered for 97 percent of expenses, while individuals with incomes at 400 percent FPL would have a basic plan covering 70 percent (the statutory minimum). These rich benefit packages, in addition to raising subsidy costs for the federal government, would insulate plan participants from the effects of higher health spending, resulting in an increase in overall health costs—exactly the opposite of the bill's purported purpose.

Medicaid Expansion: The bill would expand Medicaid to all individuals with incomes under 150 percent of the federal poverty level ($33,075 for a family of four). Under the bill, the bill's expansion of Medicaid to more than 10 million individuals would be fully paid for by the federal government only through 2014—thus imposing billions in unfunded mandates on States, which would be expected to pay nearly 10 percent of the cost of the expansion beginning in 2015.

Benefits Committee: The bill establishes a new government health board called the "Health Benefits Advisory Committee" to make recommendations on minimum federal benefit standards and cost-sharing levels. The Committee would be comprised of federal employees and Presidential appointees.

The bill eliminates language in the discussion draft of H.R. 3200 stating that Committee should "ensure that essential benefits coverage does not lead to rationing of health care." Many view this change as an admission that the bureaucrats on the Advisory Committee—and the new government-run health plan—would therefore deny access to life-saving services and treatments on cost grounds. As written, the Committee could require all Americans to obtain health insurance coverage of abortion procedures as part of the bill's new individual mandate.

Funneling Patients into Government Care

Abolition of Private Insurance Market: The bill imposes new regulations on all health insurance offerings, with only limited exceptions. Existing individual market policies could remain in effect—but only so long as the carrier "does not change any of its terms and conditions, including benefits and cost-sharing" once the bill takes effect. With the exception of these grandfathered individual plans subject to numerous restrictions, insurance purchased on the individual market "may only be offered" until the Exchange comes into effect, thus abolishing the private market for individual health insurance and requiring all non-employer-based coverage to be purchased through the bureaucrat-run Exchange.

Employer coverage shall be considered exempt from the additional federal mandates, but only for a five year "grace period"—after which all the bill's mandates shall apply. By applying new federal mandates and regulations to employer-sponsored coverage, this provision would increase health costs for businesses and their workers, encourage employers to drop existing coverage, and leave employees to access care through the government-run Exchange.

"Pay-or-Play" Mandate on Employers: The bill requires that employers offer health insurance coverage, and contribute to such coverage at least 72.5 percent of the cost of a basic individual policy—as defined by the Health Benefits Advisory Council—and at least 65 percent of the cost of a basic family policy, for full-time employees. The bill further extends the employer mandate to part-time employees, with contribution levels to be determined by the Commissioner, and mandates that any health care contribution "for which there is a corresponding reduction in the compensation of the employee" will not comply with the mandate—which would encourage them to lay off workers.

Employers must comply with the mandate by "paying" a tax of 8 percent of wages in lieu of "playing" by offering benefits that meet the criteria above. In addition, beginning in the Exchange's second year, employers whose workers choose to purchase coverage through the Exchange would be forced to pay the 8 percent tax to finance their workers' Exchange policy—even if they offer coverage to their workers.

The bill includes a limited exemption for small businesses from the employer mandate—those with total payroll under $500,000 annually would be exempt, and those with payrolls between $500,000 and

$750,000 would be subjected to lower tax penalties (2-6 percent, as opposed to 8 percent for firms with payrolls over $750,000). However, these limits are not indexed for inflation, and the threshold amounts would likely become increasingly irrelevant over time, meaning virtually all employers would be subjected to the 8 percent payroll tax.

The bill amends ERISA to require the Secretary of Labor to conduct regular plan audits and "conduct investigations" and audits "to discover non-compliance" with the mandate. The bill provides a further penalty of $100 per employee per day for non-compliance with the "pay-or-play" mandate—subject only to a limit of $500,000 for unintentional failures on the part of the employer.

The employer mandate would impose added costs on businesses with respect to both their payroll and administrative overhead. An economic model developed by Council of Economic Advisors Chair Christina Romer found that an employer mandate could result in the loss of up to 5.5 million jobs as employers lay off employees to avoid providing costly, government-forced health insurance.

Individual Mandate: The bill places a tax on individuals who do not purchase "acceptable health care coverage," as defined by the bureaucratic standards in the bill. The tax would constitute 2.5 percent of adjusted gross income, up to the amount of the national average premium through the Exchange. The tax would not apply to dependent filers, non-resident aliens, individuals resident outside the United States, and those exempted on religious grounds. "Acceptable coverage" includes qualified Exchange plans, "grandfathered" individual and group health plans, Medicare and Medicaid plans, and military and veterans' benefits.

For individuals with incomes of under $100,000, the cost of complying with the mandate would be under $2,000—raising questions of how effective the mandate will be, as paying the tax would in many cases cost less than purchasing an insurance policy. Despite, or perhaps because of, this fact, the bill language does not include an affordability exemption from the mandate; thus, if the many benefit mandates imposed raise premiums so as to make coverage less affordable for many Americans, they will have no choice but to pay an additional tax as their "penalty" for not being able to afford coverage. Then-Senator Barack Obama, pointed out in a February 2008 debate that in Massachusetts, the one State with an individual mandate, "there are people who are paying fines and still can't afford [health insurance], so now they're worse off than they were. They don't have health insurance and they're paying a fine."

Medicare Advantage: The bill reduces Medicare Advantage (MA) payment benchmarks to levels paid by traditional Medicare—which provides less care to seniors—over a three-year period. This arbitrary adjustment would reduce access for millions of seniors to MA plans that have brought additional benefits.

The bill imposes requirements on MA plans to offer cost-sharing no greater than that provided in government-run Medicare, and imposes price controls on MA plans, limiting their ability to offer innovative benefit packages. This policy would encourage plans to keep seniors sick, rather than manage their chronic disease.

The bill also gives the Secretary blanket authority to reject "any or every bid by an MA organization," as well as any bid by a carrier offering private Part D Medicare prescription drug coverage, giving federal bureaucrats the power to eliminate the MA program entirely—by rejecting all plan bids for nothing more than the arbitrary reason that an Administration wishes to force the 10 million beneficiaries enrolled in MA back into traditional, government-run Medicare against their will.

Tax Increases

Government-Forced Insurance Penalties: Offsetting payments to finance the government takeover of health care would include taxes on individuals not complying with the mandate to purchase coverage, as well as taxes and payments by businesses associated with the "pay-or-play" mandate.

Taxes on Small Businesses: The bill also imposes a new 5.4 percent "surtax" on individuals with incomes over incomes over $500,000 and families with incomes greater than $1 million. The tax would apply beginning in 2011. As more than half of all high-income filers are small businesses, this provision would cripple small businesses and destroy jobs during a deep recession.

Taxes on Health Plans: The bill prohibits the reimbursement of over-the-counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), and increases the penalties for non-qualified HSA withdrawals from 10 percent to 20 percent, effective in 2011. Because these savings vehicles are tax-preferred, adopting this prohibition would raise taxes by $8.2 billion over ten years, according to the Joint Committee on Taxation.

H.R. 3962 would place a cap on FSA contributions, beginning in 2012; contributions could only total $2,500 per year, subject to annual adjustments linked to the growth in general (not medical) inflation. Members may be concerned that these provisions would first raise taxes, and second—by imposing additional restrictions on health savings vehicles popular with tens of millions of Americans—undermines the promise that "If you like your current coverage, you can keep it." At least 8 million individuals hold insurance policies eligible for HSAs, and millions more participate in FSAs. All these individuals would be subject to additional coverage restrictions—and tax increases—under this provision.

The bill also repeals the current-law tax deductibility of subsidies provided to companies offering prescription drug companies to retirees. Many may be concerned that this provision would lead to companies dropping their current coverage as a result.

Taxes on Health Products: Finally, H.R. 3962 would impose a 2.5 percent excise tax on medical devices, beginning in 2013. Many may echo the concerns of the Congressional Budget Office and other independent experts, who have confirmed that this tax would be passed on to consumers in the form of higher prices—and ultimately higher premiums.

Budgetary Gimmicks

Unpaid-For Doctor Fix: While the Democrats claim their bill is now deficit-neutral, the majority also introduced a separate piece of stand-alone legislation (H.R. 3961). **The more than $200 billion cost of this legislation is not paid for, thus adding hundreds of billions of dollars in deficit spending and interest costs to the federal debt**. Many may also note that the Congressional Budget Office recently analyzed similar legislation (S. 1776) as raising Medicare premiums by $70 billion.

Long-Term Care Program: The bill includes a new program for long-term care services that provides a benefit of at least $50 per day to individuals unable to perform certain functions of daily living. As the long-term care program requires individuals to contribute five years' worth of premiums before becoming eligible for benefits, the program would find its revenue over the first ten years diverted to finance other spending in Democrats' health care "reform." However, the Congressional Budget Office, in analyzing similar provisions included in Section 191 of legislation considered by the Senate HELP Committee, found that "if the Secretary did not modify the program to improve its actuarial soundness, the program **would add to future federal budget deficits in a large and growing fashion** beginning a few years beyond the 10-year budget window." As even Democrats such as Senate Budget Committee Chairman Kent Conrad (D-ND) have called the program a "Ponzi scheme," many may find any legislation that relies upon such a program to maintain "deficit-neutrality" fiscally irresponsible and not credible.